

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43919**

FILED DEC 16 1957

BIRTH NO. _____		REG. DIST. NO. <u>99</u>		PRIMARY REG. DIST. NO. <u>4172</u>		Registrar's No. <u>6</u>	
1. PLACE OF DEATH a. COUNTY <u>Dekalb</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dekalb</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Stewartsville</u>		c. LENGTH OF STAY (in this place) <u>Life</u>		c. CITY OR TOWN <u>Stewartsville</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION				e. STREET ADDRESS (If rural, give location) <u>RFD #1</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>Robert</u>		b. (Middle) <u>Fountain</u>		c. (Last) <u>Shackelford Sr.</u>	
4. DATE OF DEATH		(Month) <u>11</u>		(Day) <u>23</u>		(Year) <u>57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married widowed</u>	8. DATE OF BIRTH <u>9/7/1892</u>	9. AGE (In years last birthday) <u>65</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Mins. _____	10. CITIZEN OF WHAT COUNTRY? <u>USA</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hog buyer for Lederle Serum Co.</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and State or Foreign Country) <u>Stewartsville, Mo.</u>	
13a. FATHER'S NAME <u>Robert F. Shackelford</u>		13b. MOTHER'S MAIDEN NAME <u>Arllie Whitsall</u>		14. NAME OF HUSBAND OR WIFE <u>Vera Shackelford</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>493-42-4131</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Robt. F. Shackelford Jr. Stewart</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Sudden cardiac dilatation.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
II. ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>Calcific aortic stenosis</u>					yrs. _____
DUE TO (c) <u>Arteriosclerotic heart disease</u>		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertensive cardiovascular disease with left ventricular hypertrophy and coronary insufficiency.</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4200</u>					20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 11</u> , 19 <u>57</u> , to <u>Oct. 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct. 8</u> , 19 <u>57</u> , and that death occurred at <u>5:00 P.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Barry G. Fetter, Jr. M.D.</u>		(Degree or title)		23b. ADDRESS <u>Phy. & Surg. Bldg. St. Joseph, Missouri</u>		23c. DATE SIGNED <u>11/24/57</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>11/25/57</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Stewartsville</u>		24d. LOCATION (City, town, or county) (State) <u>Stewartsville, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>12-7-57</u>		REGISTRAR'S SIGNATURE <u>Race Davidson</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W.E. Summersfield, Stewartsville, Mo.</u>			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *W. E. Summerfield*

Licensed Embalmer No. *5007*

P. O. Address *Stewartville, Md.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.